# Pregnancy Exercise

## Getting to Know You

Thank you for taking the time to complete the following questions. This helps me to determine the best approach to help you reach your goals.

| | |
|---|---|
| Name: | DOB: |
| Home Address: | Home Phone: |
| | Work Phone: |
| Occupation: | Mobile: |
| Email Address: | |
| Midwife: | Ethnicity: |
| In Case of Emergency | Phone Numbers |
| Name: | |

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| How did you hear about me? |

| Do you have any of the following medical conditions? | | |
|---|---|---|
| | Yes/No | Please give details |
| A Heart Condition | | |
| Diabetes—Type 1 or 2 | | |
| Asthma | | |
| High Blood Pressure | | |
| Epilepsy | | |
| Joint Problems | | |
| Have you had any major operations | | |
| Do you take any medication? | | |
| Any other medical conditions I should know about? | | |

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| How many weeks pregnant are you currently? Your Due Date:<br>Are you expecting twins or triplets? | |
| Have you sought advice from medical practitioner in regards to exercise? Explain | |
| Are there any complications with the pregnancy? Explain | |
| Are you currently exercising, or have you done any training previously, if so what type/when/how often? | |
| List the ages of any other children you have given birth to | |
| Do you experience pelvic pain during this pregnancy? Have you had clearance from a health provider to exercise now? Explain | |
| Do you have an abdominal separation? Have you had clearance from a health provider to exercise? Explain. Write unknown if you don't know. | |

| Past Exercise Experience | |
|---|---|
| | Please give details |
| What exercise do you enjoy? | |
| What don't you enjoy doing? | |
| If this is not your first pregnancy did you exercise during previous pregnancies? Explain | |
| What support do you expect from me as your trainer? | |
| What do you want to achieve in these sessions? | |

| General Health |
|---|

1. Do you feel any pain or clicking in the front or back of your pelvis? YES NO
2. Do you have ongoing back, pelvis, groin or abdominal pain? YES NO
3. Do you feel pain in any other joints in your body? YES NO
4. Do you have any pins and needles anywhere? YES NO
5. Do you have pain around the coccyx/tailbone? YES NO
6. Do you experience episodes of dizziness? YES NO
7. Do you experience difficulty breathing, feeling short of breath? YES NO
8. Do you have high blood pressure or high cholesterol? YES NO
9. Have you ever had abnormal heart rate, palpitations or irregular heartbeat? YES NO
10. Do you experience an increase in headaches during or after exercise? YES NO
11. Do you ever leak urine when you cough, sneeze, laugh or run? YES NO
12. Do you often need to go to the toilet in a hurry or find it difficult to get there in time if you are out and about? YES NO
13. Do you ever lose control of your bowel or accidentally pass wind a lot? YES NO
14. Do you have haemorrhoids that aren't improving? YES NO
15. Have you been experiencing constipation? YES NO
16. Do you experience and feeling of "dragging, heaviness or bulging" in your vaginal area (worse if tired or at the end of the day? YES NO
17. Do you experience difficulty with any daily task due to pain, leakage or any other symptoms? YES NO
18. As far as you know, is there a risk of premature labour (i.e. incomplete cervix, pre-eclampsia, multiple pregnancies? YES NO
19. Have you had any episodes of vaginal bleeding or amniotic fluid leakage? YES NO

If answered yes to any of the above 19 questions I may require written consent from your health practitioner to continue.

**Informed Consent**
I hereby acknowledge that the information provided above regarding my health is, to the best of my knowledge, correct. I will inform you immediately if there are any changes to my health status.

**Disclaimer**
I acknowledge that participating in physical activity carries a risk and I accept all responsibility for that risk.

Client Signature: ..... Trainer's Signature: .....

Date: ..... Date: .....

Fit4 consumption